

COMPREHENSIVE PERINATAL SERVICES PROGRAM COMBINED 3rd TRIMESTER REASSESSMENT

Client Name _____ DOB _____ DATE _____

ANTHROPOMETRIC <input type="checkbox"/> WT. GRID PLOTTED Wt. this visit: _____ Weeks Gestation: _____ Gain Since Last Visit: _____ Total Wt. Gain _____ Comment: _____ 	Substance Abuse: 12. Are you smoking at all? <input type="checkbox"/> Y <input type="checkbox"/> N If YES, how many cigarettes per day? _____ 13. How often do you drink beer, wine, or liquor? _____ 14. What drugs have you used since becoming pregnant? _____
BIOCHEMICAL Blood _____ Date Collected: _____ Hemoglobin: H L Hematocrit: H L MCV: H L Albumin: H L Glucose: H L GTT H L 	Labor and Delivery 15. Have you had a hospital tour <input type="checkbox"/> Y <input type="checkbox"/> N 16. Do you need information about what will happen during labor and delivery? <input type="checkbox"/> Y <input type="checkbox"/> N
Urine _____ Date Collected: _____ Glucose: + - Protein: + - Ketones: + - 	Health Education Goals:
CURRENT CLINICAL Blood Pressure: _____/_____ Edema: _____ 1. Schedule test procedures? <input type="checkbox"/> Y <input type="checkbox"/> N If YES, please list: _____ 2. Taking prenatal vitamins <input type="checkbox"/> Y <input type="checkbox"/> N Iron? <input type="checkbox"/> Y <input type="checkbox"/> N 3. Taking new medications or herbs? <input type="checkbox"/> Y <input type="checkbox"/> N If YES, please explain: _____ 4. Significant changes since last assessment? <input type="checkbox"/> Y <input type="checkbox"/> N If YES, please explain: _____ Clinical Update from previous visit: _____ 	PSYCHOSOCIAL 17. Where are you living right now? _____ 18. How many people are living with you? _____ 19. If you are worried about something, who do you talk to? _____ 20. Do you have : <input type="checkbox"/> electricity <input type="checkbox"/> hot water <input type="checkbox"/> telephone <input type="checkbox"/> transportation <input type="checkbox"/> heating <input type="checkbox"/> refrigerator <input type="checkbox"/> stove/oven 21. Are you able to buy enough food? <input type="checkbox"/> Y <input type="checkbox"/> N 22. Are you able to pay rent? <input type="checkbox"/> Y <input type="checkbox"/> N 23. Are you able to pay other bills? <input type="checkbox"/> Y <input type="checkbox"/> N 24. How do you feel about this pregnancy? _____ 25. Since becoming pregnant, have you had? (<input checked="" type="checkbox"/> if yes) <input type="checkbox"/> trouble sleeping <input type="checkbox"/> sadness <input type="checkbox"/> worried feelings <input type="checkbox"/> crying <input type="checkbox"/> depression <input type="checkbox"/> sadness <input type="checkbox"/> none <input type="checkbox"/> other _____ 26. Since becoming pregnant, have you been slapped, hit, or otherwise hurt by someone? If yes by whom? _____
NUTRITION 5. Have your eating habits changed since your last assessment? <input type="checkbox"/> Y <input type="checkbox"/> N If YES, explain: _____ Dietary Assessment <input type="checkbox"/> 24 hour recall completed Dietary Goals/Comments: _____ Infant Feeding 6. How do you plan to feed your baby? <input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Both <input type="checkbox"/> Not sure 7. Have you breastfed a baby before? <input type="checkbox"/> Y <input type="checkbox"/> N If YES, how long did you breastfeed? _____ 	REFERRALS: <input type="checkbox"/> WIC Date enrolled _____ Appointment Date _____ <input type="checkbox"/> Car seat class Date attended _____ Other referrals 1) _____ Date _____ 2) _____ Date _____ MATERIALS GIVEN: <input type="checkbox"/> Family Planning <input type="checkbox"/> Infant Feeding <input type="checkbox"/> other _____ ASSESSMENT SUMMARY:
HEALTH EDUCATION 8. Do you have an infant car seat? <input type="checkbox"/> Y <input type="checkbox"/> N 9. Do you have a doctor for the baby? <input type="checkbox"/> Y <input type="checkbox"/> N 10. Do you know what birth control you will use? <input type="checkbox"/> Y <input type="checkbox"/> N 11. Have you receive counseling on HIV (AIDS)? <input type="checkbox"/> Y <input type="checkbox"/> N 	R/A Completed By: Time spent in minutes: Nutrition _____ Health Education _____ Psychosocial _____